Washington State Department of Social & Health Services
DCS Division of Child Support

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
DIVISION OF CHILD SUPPORT (DCS)

Monthly Summary Sheet - Unreimbursed Medical Expenses for Children

INSTRUCTIONS

- Except for your signature, print all responses. Use blue or black ink only.
- For each month, enter the month, the year, and the totals for the month from the ***Detail Sheet***.
- Provide complete information for each column below.
- You must submit the records supporting your claim (bills, receipts, explanations of benefits, cancelled check, etc). **DCS will disclose the expense records to the parent who is required to pay. Delete any personal information from the records that you do not want disclosed. Keep the originals or copies (with all information visible) of the records for future use.**
- Additional copies of this form are available on the DCS web site at www1.dshs.wa.gov/dcs/Resources/Forms.asp

NAME OF PARENT REQUIRED TO PAY	DCS CASE NUMBER

MONTH/YEAR	TOTAL AMOUNT BILLED	TOTAL AMOUNT ALLOWED BY INSURANCE	TOTAL AMOUNT PAID BY INSURANCE	TOTAL UNINSURED MEDICAL EXPENSES FOR CHILDREN
TOTALS				

Amount the parent paid directly to you for these medical expenses: $ _____

I have not received any payments for these expenses other than what is shown above.

I declare under penalty of perjury, under the laws of the state of Washington, that the foregoing is true and correct.

Signed at _____ _____

City/State Date

_____

Your Signature

_____

Your Printed Name

FG VER: (1.0)